
Government of the District of Columbia



Executive Office of the Mayor

Testimony of
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**UNITED STATES SENATE
COMMITTEE ON APPROPRIATIONS
SUBCOMMITTEE ON THE DISTRICT OF COLUMBIA**

THE HONORABLE SAM BROWNBACK

**Hearing on Healthcare in the District of Columbia:
Access to Primary Care and Affordable Health Insurance.**

April 6, 2006

Good afternoon Senator Brownback and distinguished members of the Committee. I am Brenda Donald Walker, District of Columbia Deputy Mayor for Children, Youth, Families and Elders. I am here today with Dr. Gregg Pane, Director of the District's Department of Health. I am very pleased to be here to discuss the status of healthcare in the District and opportunities for the District and the Federal government to work together to improve health outcomes in our nation's capital. Over the past seven years of the Williams Administration, we have made significant progress on several fronts, but there is still much work to be done.

The most significant accomplishment of this Administration is in the area of health coverage. Five years ago, the Mayor made the difficult decision, supported by Congress and the former Financial Control Board, to close the financially and medically troubled DC General Hospital. This closure was met with significant opposition from the DC hospital industry, employees of the hospital, and healthcare advocates, who made doomsday predictions about the impact of the closure. However, by closing the hospital, the Mayor freed up significant local funds which were used to start the DC Healthcare Alliance (the Alliance), a program that offers comprehensive health coverage to all District residents under 200% of the Federal Poverty Level (FPL) who don't qualify for Medicaid. The Alliance, now five years old, is routinely lauded as one of Mayor Williams' most important accomplishments. Through the Alliance, we now offer primary and preventive care, as well as choice of healthcare provider, to roughly 30,000 District residents who used to receive most of their care in the DC General emergency room. Since the early days of the Alliance, ER visits among the Alliance population have decreased, inpatient admissions have declined and primary care visits have increased. We have also begun to see a decline in "avoidable hospitalizations", which are preventable through adequate primary and preventive care. This trend is particularly evident for District children. This means that we are keeping District residents healthier and spending taxpayer dollars more wisely. Over the next several months, we will be significantly improving the ability of the Alliance to monitor health outcomes by transitioning it to a managed care model, similar to our DC Healthy Families Medicaid program.

In addition to the creation of the Alliance program, Mayor Williams implemented SCHIP (State Children's Health Insurance Program) in 1997, expanding Medicaid coverage to children and parents from 100% to 200% of poverty. With the expansion of Medicaid and the creation of the Alliance, DC is now the only jurisdiction in the U.S. that offers health coverage to all residents under 200% of poverty. This expansive health coverage policy is reflected in District statistics on the uninsured. In 2003, the Kaiser Family Foundation found that the District's rate of uninsurance was just 9% compared to a national rate of 21%. In a more recent study, the Urban Institute found that just 5% of the District population is both uninsured and over 200% of poverty, without access to a public insurance program. The Mayor has proposed to expand coverage even further in his recent Fiscal Year 2007 budget submission. The budget offers Medicaid coverage for children up to 300% of poverty, and it closes a major gap in the Medicaid benefit package by adding an adult dental benefit.

Despite these high rates of insurance in the District, not every District resident has ready access to physician and hospital services. A 2004 report by the RAND Corporation and Brookings Institution, sponsored by the DC Primary Care Association, showed that in some neighborhoods, particularly on the East side of the city, as many as 25% of the population has no regular source of primary care. In addition, there is little access to specialty, diagnostic, inpatient and emergency care on the East side of the District. Many patients travel long distances to reach doctors, health centers and hospitals, which are primarily located in the Northwest quadrant of DC, even though the highest concentrations of chronically ill residents and emergency transports come from the East side of the city.

To address this issue of lack of access to care, the Mayor has supported two major initiatives. The Medical Homes initiative, in partnership with the DC Primary Care Association and the Brookings Institution, is designed to increase the availability of primary care health centers in underserved neighborhoods and to improve the quality of care in health centers across the District. The National Capital Medical Center proposal, in partnership with Howard University, to build a new private hospital is designed to ensure access to specialty, diagnostic, inpatient, emergency, and trauma care to residents on the eastern side of the city. Through these two initiatives, the city will provide capital funding to spur the development of new private nonprofit healthcare facilities in underserved neighborhoods. As a result, residents with either public or commercial health insurance will have somewhere to use their insurance cards.

Health coverage programs for low-income individuals are largely in place in the District, and initiatives to expand the private healthcare delivery system are moving forward. However, the District continues to face some very dire health statistics. Our rate of chronic illness is much higher than the national average, especially in some parts of the city. For example, 20% of Ward 8 residents and 13.5% of Ward 7 residents reported being diagnosed with diabetes in 2004. Nationally the figure is 7.0%.¹ The District has one of the nation's highest asthma rates. In 2002, 13% of Ward 1 residents and 12.3% of Ward 7 residents reported having been diagnosed with asthma, while the national was just 8.2%.² In 2003, the District experienced an alarming rate of death from hypertension of 64.2 per 100,000, which is significantly higher than the national average of 7.5.³

In addition, infant death rates, primarily attributable to poor prenatal care and risky behavior during pregnancy, are very high in certain parts of the city. For example, in

¹ Behavioral Risk Factor Surveillance System, 2004; analysis by the National Center for Chronic Disease Prevention and Health Promotion, Division of Nutrition and Physical Activity, Centers for Disease Control and Prevention, available at <http://apps.nccd.cdc.gov/brfss/list.asp?cat=DB&yr=2004&qkey=1363&state=All>.

² Centers for Disease Control and Prevention (CDC). Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2004. Available at <http://apps.nccd.cdc.gov/brfss/list.asp?cat=AS&yr=2004&qkey=4416&state=All>.

³ DC Department of Health Vital Statistics, 2003.

Wards 8, 7, and 5, the infant death rates are 18.4, 12.9, and 12.6 per 100,000 respectively, compared to a national rate of 6.9.³ Our rates of communicable disease, most notably HIV/Aids, are deplorable. In 2004, the rate of HIV/Aids infection in the District was 179.2 per 100,000 residents compared with 15.0 nationally.⁴ And our rate of substance abuse is 9.6%, 52% higher than the nationwide rate of 6.3%. Approximately 60,000 residents--nearly 1 in 10--are addicted to illegal drugs or alcohol.

I will note a few silver linings in our health outcomes data. Some of our health statistics are better or equal to national averages. For example, the District's rate of school age immunization is now 96%, one of the highest in the nation.⁵ The District death rate from strokes is significantly lower than national average, with a rate of 37.4 per 100,000 compared with 54.3 nationally in 2003.⁶ The prevalence of smoking in the District has gone down to 20.8 % and is now equal to the US average.⁷ I will also point out that the District frequently compares very unfavorably to states and to the national average, where a more apples-to-apples comparison to other urban areas would show more comparable data.

Despite these silver linings, the District's health status in general is in need of substantial improvement. We believe that over time, health coverage and access to medical facilities will improve these outcomes. But in order to significantly move our health indicators, we must attempt to address the root causes of illness, many of which are linked to individual behaviors and lifestyles, and we must target hard-to-reach populations. We have recently started a number of initiatives designed to address health outcomes.

We have taken very seriously a report on the HIV/AIDS epidemic in DC, authored last year by the DC Appleseed Foundation. We are beginning to implement many of the recommendations from that report. First, just this week, we are announcing a high-level HIV/AIDS Task Force to develop a full plan to address the epidemic. Second, we are also pleased to announce an academic public health partnership with George Washington University School of Public Health--a partnership that will help us improve the surveillance activities and monitoring of our local epidemic. Third, consistent with President Bush's State of the Union message about the importance of HIV testing and outreach to communities with high rates of HIV infection and the CDC's initiative to make HIV testing routine in all medical settings, the District of Columbia will soon undertake an initiative to encourage widespread testing, so that everyone in DC knows their HIV status. Finally, also consistent with President Bush's concerns about services to incarcerated populations, the District of Columbia will expand HIV testing in the DC correctional facilities.

⁴ Table 14, HIV/AIDS Surveillance Report: Cases of HIV Infection and AIDS in the United States, 2004, Volume 16, National Center for HIV, STD and TB Prevention, Centers for Disease Control and Prevention, Department of Health and Human Services, 2005. Available at <http://www.cdc.gov/hiv/stats/2004SurveillanceReport.pdf>.

⁵ Immunization rates data, DC Public Schools

⁶ DC Department of Health Vital Statistics, 2003.

⁷ America's Health Ranking, United Health Foundation, 2005.

Another area of focus in the past year has been generally improving corrections healthcare. Just yesterday, the Mayor announced an innovative new partnership between the District's largest Federally Qualified Health Center, Unity Health Care, and the Department of Corrections to provide care to inmates in District jail facilities. The goal of the partnership is to create continuity of care from community health facilities to jail health facilities, since much of the population overlaps. Incarceration is an opportunity to identify and begin treatment for chronic and communicable diseases. By partnering with Unity, the District will ensure that treatment continues after inmates are released into the community. The District is fortunate to have received significant support through the Robert Wood Johnson Foundation to implement this new model in October.

To address quality of care for chronic illnesses, both of DC's public health coverage programs, Medicaid and the Alliance, have selected quality performance metrics and are now implementing a plan to hold contracted managed care organizations accountable for improvement on their scores. Ultimately, we plan to create pay-for-performance incentives to catalyze improvements in disease management, and ultimately, District-wide health outcomes.

The District's new Smoke-Free legislation, banning tobacco use in most restaurants and bars, begins to take effect this week. In addition, in the past year, the Department of Health sponsored town hall meetings on healthcare disparities in every Ward of the District. These forums allowed us to gather information from District residents and begin to promote healthier lifestyles.

But we know there is more to be done. In our latest strategic planning cycle, we identified several major initiatives to address health outcomes that would benefit from a Federal partnership, and also potentially serve as demonstration projects that, if successful, could be replicated in other parts of the country.

One such initiative currently in development is a comprehensive, District-wide prevention and disease management program. This program would include three different components targeting both healthcare providers and patients. The first aspect of the initiative would be a major media campaign targeted at the general District population to communicate the key behaviors necessary to stay healthy. Supporting the media blitz, the second component would be a community health outreach worker program. This program would rely on peer-to-peer education about how to get screened for and manage chronic illnesses, as well as how to lead a healthy lifestyle. We would target this program to specific neighborhoods and populations with negative health indicators. For example, we could develop a group of Spanish-speaking outreach workers for the Latino immigrant community or a group of young adult outreach workers to target teens. Outreach would be conducted in places that already cater to key target populations, such as churches and barber shops. The outreach worker model has the added benefit of being a workforce development program, providing jobs and a career ladder for members of lower-income communities. The third component of the disease management initiative

would be a District-wide chronic disease collaborative. Under this model, physicians and community health centers across the city would work together to simultaneously implement disease management methods to better track care and outcomes of populations with chronic illnesses. We believe that this type of multi-pronged effort to prevent and treat chronic illness is a key step toward progress on the District's negative health indicators. It would surely benefit from federal start-up funds.

As an aside, one challenge in developing such a program is that currently, federal funds supporting disease management are narrowly focused on specific diseases, making it difficult to create programs that target whole neighborhoods and sub-populations. We have begun a very positive relationship with the Centers for Disease Control to try to increase our flexibility, but federal funds ideally would allow more broad-based expenditures.

Another area for a potential partnership is the creation of a National Capital Area Regional Health Information Exchange. Healthcare data sharing, with appropriate privacy and security protections, enables better coordination among emergency rooms, primary care physicians, specialists, and hospitals. This improved coordination allows primary care physicians to better manage chronic illnesses. It also decreases the incidence of medical errors and minimizes duplicative health services, ultimately slowing the growth of public and private healthcare costs. In addition, the data collected can be used to improve disease surveillance and healthcare policy-making. The District and surrounding jurisdictions in Maryland and Virginia are now in the early stages of developing a Regional Health Information Organization for the National Capital Region to develop a technical model and governance structure for health information exchange among hospitals, physicians, and payors. In the Mayor's Fiscal 2007 budget, we funded the implementation of electronic medical records for all Medical Homes community health centers in the District. This is a major building block for health information exchange. In addition, we have begun an exciting pilot program called QuickConnect, which electronically provides key health records from hospital emergency rooms to community health centers, enabling them to follow up with patients who have visited the ER.

As a multi-state region, the National Capital Area is an ideal location to demonstrate data-sharing, because the ultimate goal is to foster a national, interstate model for data sharing. In addition, the region continues to be a target for terrorist attacks, and health data sharing will be crucial in responding to any major disaster. Finally, health coverage in this region is largely funded by the federal government, through the Federal Employees Health Benefits Plan, Medicare, and Medicaid. That means that the expected cost savings of health information exchange will accrue to taxpayers. We are currently seeking funding to fully launch the National Capital Area Regional Health Information Organization. We envision that this organization will ultimately adopt a self-sustaining business model.

Another potential federal/local initiative would be a partnership to further expand health coverage in the District. While we lead the nation in offering health coverage to low-

income individuals, there is still a gap for low to moderate income individuals, especially between 200 and 400% of poverty. These people earn too much to qualify for public programs, but they have difficulty affording private insurance. In the last year, through a Department of Health and Human Services funded State Planning Grant for Health Coverage, we have explored numerous options for expanding coverage to this population. One such model would subsidize private commercial insurance through a state-run stop-loss pool. Another model would allow moderate income individuals to buy into District Medicaid and Alliance managed care plans, with sliding-scale premiums according to income level. We have also evaluated the Equal Access model, which would open the DC Government employee health purchasing pool to private employers. All of these models would require some level of sliding-scale subsidy in order to attract members.

Finally, additional federal funding for our existing District health coverage programs, Medicaid and the Alliance, would allow us to continue to expand the District's market-based model for coverage to the low-income uninsured. With the Alliance, the District moved from a government-run, safety-net public health system to a market-based system for covering difficult populations, such as the homeless. As mentioned earlier, this new model appears to be making significant improvements to care. Until now, we have been able to budget enough local dollars to cover all eligible Alliance applicants. The District currently invests nearly \$100M in local dollars for the Alliance. However, we have been quite successful in expanding the Alliance program, and membership has increased steadily, up 25% in the past year alone to over 30,000 members. Soon, it is likely that demand for the program will outstrip the dollars budgeted for the program. In order to continue enrolling all eligible District residents, funding will have to increase in the next several years. The federal government could offer some flexibility that would allow the Alliance to transition to a Medicaid waiver program, thus qualifying for federal funding. Another alternative would be to increase the District's FMAP rate for Medicaid, which would free up additional local funds for the Alliance program. Despite the fact that one in four District residents is covered by Medicaid, the District still only has a 70% FMAP rate, compared to states such as Mississippi, which have rates as high as 77%.

Thank you for this opportunity to testify today. Dr. Pane or I would be happy to answer your questions.